

		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0043646</u></p> <p>Facility Name: <u>PITTSFIELD HEALTHCARE CENTER</u></p> <p>Address: <u>1400 E. WASHINGTON STREET</u> <u>PITTSFIELD</u> <u>62363</u> Number City Zip Code</p> <p>County: <u>PIKE</u></p> <p>Telephone Number: <u>(217) 285-4491</u> Fax # <u>(217) 285-4776</u></p> <p>IDPA ID Number: <u>830320180022</u></p> <p>Date of Initial License for Current Owners: <u>02/07/98</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>JEFFREY E. BOLAND</u> Telephone Number: <u>(717) 213-3125</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1165 678 1297 824"> Officer or Administrator of Provider </td> <td data-bbox="1297 678 1942 824"> (Signed) _____ (Date) _____ (Type or Print Name) <u>LARRY BONDS</u> (Title) <u>PRESIDENT</u> </td> </tr> <tr> <td data-bbox="1165 824 1297 1036"> Paid Preparer </td> <td data-bbox="1297 824 1942 1036"> (Signed) _____ (Date) _____ (Print Name and Title) <u>JEFFREY E. BOLAND, DIRECTOR</u> (Firm Name & Address) <u>ZA CONSULTING</u> <u>305 NORTH FRONT STREET, HARRISBURG, PA 17101</u> (Telephone) <u>(717) 213-3125</u> Fax # <u>(717) 233-4633</u> </td> </tr> </table> <p align="center"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 </p> <p align="right">Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>LARRY BONDS</u> (Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>JEFFREY E. BOLAND, DIRECTOR</u> (Firm Name & Address) <u>ZA CONSULTING</u> <u>305 NORTH FRONT STREET, HARRISBURG, PA 17101</u> (Telephone) <u>(717) 213-3125</u> Fax # <u>(717) 233-4633</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.																												
	<input checked="" type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>LARRY BONDS</u> (Title) <u>PRESIDENT</u>																												
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>JEFFREY E. BOLAND, DIRECTOR</u> (Firm Name & Address) <u>ZA CONSULTING</u> <u>305 NORTH FRONT STREET, HARRISBURG, PA 17101</u> (Telephone) <u>(717) 213-3125</u> Fax # <u>(717) 233-4633</u>																												

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER# 0043646 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>8</u>	Skilled (SNF)	<u>8</u>	<u>2,928</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>91</u>	Intermediate (ICF)	<u>91</u>	<u>33,306</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,432</u>	<u>1,432</u>	8
9	SNF/PED					9
10	ICF	<u>20,652</u>	<u>5,545</u>	<u>82</u>	<u>26,279</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,652</u>	<u>5,545</u>	<u>1,514</u>	<u>27,711</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.48%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/7/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/7/98 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 8 and days of care provided 1,432Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, INC.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER # 0043646 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	112,120	7,845	4,041	124,006		124,006	(218)	123,788			1
2	Food Purchase		89,852		89,852		89,852		89,852			2
3	Housekeeping	55,187	9,920	55	65,162		65,162		65,162			3
4	Laundry	30,405	8,991	594	39,990		39,990		39,990			4
5	Heat and Other Utilities			55,980	55,980		55,980		55,980			5
6	Maintenance	18,811	12,902	26,495	58,208		58,208		58,208			6
7	Other (specify):*											7
8	TOTAL General Services	216,523	129,510	87,165	433,198		433,198	(218)	432,980			8
	B. Health Care and Programs											
9	Medical Director			5,650	5,650		5,650		5,650			9
10	Nursing and Medical Records	655,457	42,227	42,503	740,187		740,187	5,030	745,217			10
10a	Therapy		129	93,419	93,548		93,548		93,548			10a
11	Activities	29,002	977	2,501	32,480		32,480		32,480			11
12	Social Services	18,190		2,501	20,691		20,691	61	20,752			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	702,649	43,333	146,574	892,556		892,556	5,091	897,647			16
	C. General Administration											
17	Administrative			88,942	88,942		88,942	17,792	106,734			17
18	Directors Fees											18
19	Professional Services			625	625		625	35,762	36,387			19
20	Dues, Fees, Subscriptions & Promotions			6,380	6,380		6,380	(4,590)	1,790			20
21	Clerical & General Office Expenses	30,511	9,116	27,415	67,042		67,042	79,459	146,501			21
22	Employee Benefits & Payroll Taxes			82,634	82,634		82,634	23,831	106,465			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,634	4,634		4,634	3,939	8,573			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			35,480	35,480		35,480	23,809	59,289			26
27	Other (specify):*											27
28	TOTAL General Administration	30,511	9,116	246,110	285,737		285,737	180,002	465,739			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	949,683	181,959	479,849	1,611,491		1,611,491	184,875	1,796,366			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			101,580	101,580		101,580		101,580			30
31	Amortization of Pre-Op. & Org.			259,222	259,222		259,222	(246,245)	12,977			31
32	Interest			408,612	408,612		408,612		408,612			32
33	Real Estate Taxes			48,565	48,565		48,565		48,565			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,905	1,905		1,905		1,905			35
36	Other (specify):* Mtg. Guarantee			85,050	85,050		85,050		85,050			36
37	TOTAL Ownership			904,934	904,934		904,934	(246,245)	658,689			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,567	28,904	43,471		43,471		43,471			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		14,567	83,256	97,823		97,823		97,823			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	949,683	196,526	1,468,039	2,614,248		2,614,248	(61,370)	2,552,878			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(218)	1		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(683)	21		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(4,590)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Attached	(255,751)	Var		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (261,242)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	199,872	VAR	34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 199,872		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (61,370)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
PITTSFIELD HEALTHCARE CENTER

Page 5A

Report Period Beginning: ID# 0043646
Ending: 01/01/00
12/31/00

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Vending Revenue	\$ (435)	21	1
2	Other Revenue	(267)	21	2
3	Business Meals	(596)	21	3
4	Extraordinary Items	(8,208)	21	4
5	Amortization-Goodwill	(246,245)	31	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23

24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52

53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83

84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(255,751)		90

Summary A

12/31/00

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER# 0043646

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(246,245)	0	0	0	0	0	0	0	0	0	0	(246,245)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(246,245)	0	0	0	0	0	0	0	0	0	0	(246,245)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(261,242)	29,051	170,821	0	0	0	0	0	0	0	0	(61,370)	45

Facility Name & ID Number **PITTSFIELD HEALTHCARE CENTER** # **0043646** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached List		See Attached List		Eden & Associates, Inc	Wilson, WY	Consulting

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	10 Contract Services - RN	\$	Senior Living Properties, LLC	100.00%	\$ 535	\$ 535 1
2	V	10 Contract Services - RN		Senior Living Properties, LLC	100.00%	2,055	2,055 2
3	V	10 Contract Services - RN		Senior Living Properties, LLC	100.00%	2,440	2,440 3
4	V	12 Social Services Consultant	2,501	Senior Living Properties, LLC	100.00%	2,562	61 4
5	V	17 Contract Services - Business Office	21,551	Senior Living Properties, LLC	100.00%	33,244	11,693 5
6	V	17 Contract Services - Administrator	67,391	Senior Living Properties, LLC	100.00%	73,490	6,099 6
7	V	24 Travel	1,920	Senior Living Properties, LLC	100.00%	5,676	3,756 7
8	V	21 Business Meals	174	Senior Living Properties, LLC	100.00%	511	337 8
9	V	24 Seminars	85	Senior Living Properties, LLC	100.00%	268	183 9
10	V	21 Office Supplies	5,695	Senior Living Properties, LLC	100.00%	6,195	500 10
11	V	21 Supplies	1,567	Senior Living Properties, LLC	100.00%	1,663	96 11
12	V	21 Postage	1,372	Senior Living Properties, LLC	100.00%	1,391	19 12
13	V	21 Telephone	10,332	Senior Living Properties, LLC	100.00%	11,609	1,277 13
14	Total		\$ 112,588			\$ 141,639	\$ * 29,051 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PITTSFIELD HEALTHCARE CENTER**# **0043646**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 EDP Services	\$	Senior Living Properties, LLC	100.00%	\$ 5,663	\$ 5,663	15
16	V	19 Legal Fees	625	Senior Living Properties, LLC	100.00%	12,446	11,821	16
17	V	19 Accounting Fees		Senior Living Properties, LLC	100.00%	23,369	23,369	17
18	V	26 Insurance - General Liability	31,973	Senior Living Properties, LLC	100.00%	36,199	4,226	18
19	V	26 Insurance - Property & Contents	3,407	Senior Living Properties, LLC	100.00%	22,815	19,408	19
20	V	26 Insurance - Other	100	Senior Living Properties, LLC	100.00%	275	175	20
21	V	22 Workers Compensation Claims	3,173	Senior Living Properties, LLC	100.00%	8,464	5,291	21
22	V	22 Health & Dental Insurance		Senior Living Properties, LLC	100.00%	18,540	18,540	22
23	V	21 Management Fees		Senior Living Properties, LLC	100.00%	27,598	27,598	23
24	V	19 Legal Fees		Senior Living Properties, LLC	100.00%	572	572	24
25	V	21 Management Fees		Senior Living Properties, LLC	100.00%	54,158	54,158	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 39,278			\$ 210,099	\$ * 170,821	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER # 0043646 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER # 0043646 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Senior Living Properties, LLC

Street Address 3395 North Pines Drive, Suite 102

City / State / Zip Code Wilson, Wyoming 83014

Phone Number (307) 739-1209

Fax Number (307) 739-1217

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	\$ 13,034	\$ 27,711	\$ 535	1	
2	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	50,078	27,711	2,055	2	
3	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	59,476	27,711	2,440	3	
4	12	Social Services Consultant	Resident Days (IL Only)	675,434	31	1,475	27,711	61	4	
5	17	Contract Services - Business Office	Resident Days (Total)	1,728,555	88	729,382	27,711	11,693	5	
6	17	Contract Services - Administrator	Resident Days (IL Only)	675,434	31	148,670	27,711	6,099	6	
7	24	Travel	Resident Days (IL Only)	675,434	31	91,552	27,711	3,756	7	
8	21	Business Meals	Resident Days (IL Only)	675,434	31	8,225	27,711	337	8	
9	24	Seminars	Resident Days (IL Only)	675,434	31	4,452	27,711	183	9	
10	21	Office Supplies	Resident Days (IL Only)	675,434	31	12,185	27,711	500	10	
11	21	Supplies	Resident Days (IL Only)	675,434	31	2,350	27,711	96	11	
12	21	Postage	Resident Days (IL Only)	675,434	31	466	27,711	19	12	
13	21	Telephone	Resident Days (IL Only)	675,434	31	31,125	27,711	1,277	13	
14	21	EDP Services	Resident Days (Total)	675,434	31	138,040	27,711	5,663	14	
15	19	Legal Fees	Resident Days (Total)	1,728,555	88	737,379	27,711	11,821	15	
16	19	Accounting Fees	Resident Days (Total)	1,728,555	88	1,457,713	27,711	23,369	16	
17	26	Insurance - General Liability	Resident Days (Total)	1,728,555	88	263,635	27,711	4,226	17	
18	26	Insurance - Property & Contents	Resident Days (Total)	1,728,555	88	1,210,642	27,711	19,408	18	
19	26	Insurance - Other	Resident Days (Total)	1,728,555	88	10,924	27,711	175	19	
20	22	Workers Compensation Claims	Resident Days (Total)	1,728,555	88	330,015	27,711	5,291	20	
21	22	Health & Dental Insurance	Resident Days (Total)	1,728,555	88	1,156,469	27,711	18,540	21	
22	21	Management Fees	Resident Days (Total)	1,728,555	88	1,721,509	27,711	27,598	22	
23	19	Legal Fees	Resident Days (IL Only)	675,434	31	13,948	27,711	572	23	
24	22	Workers Compensation Claims	Resident Days (IL Only)	675,434	31	1,320,062	27,711	54,158	24	
25	TOTALS					\$ 9,512,806	\$	\$ 199,872	25	

Facility Name & ID Number PITTSFIELD HEALTHCARE CENTER # 0043646 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Senior Living Properties, LLC

Street Address 3395 North Pines Drive, Suite 102

City / State / Zip Code Wilson, Wyoming 83014

Phone Number (307) 739-1209

Fax Number (307) 739-1217

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Management Fees	Resident Days (IL Only)	675,434	31	\$ 500,000	\$	27,711	\$ 20,513	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 500,000	\$		\$ 20,513	25

Facility Name & ID Number **PITTSFIELD HEALTHCARE CENTER**# **0043646**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC Comm. Mortg. Corp.		X	Acquisition	\$32,620.00	02/06/98	\$ 4,652,436	\$ 4,355,201	02/01/08	0.0681	\$ 314,944	1	
2	CCS Note		X	Acquisition	\$1,201.00	02/06/98	205,860	205,860	02/06/08	0.0700	26,056	2	
3	See Attachment		X	Acquisition	\$1,201.00	02/06/98	205,860	205,860	02/06/08	0.0700	26,056	3	
4												4	
5												5	
	Working Capital												
6	Health Care Financial Partners		X	Working Capital	None	02/06/98	66,864	87,444	Demand	Prime + 2%	41,556	6	
7												7	
8												8	
9	TOTAL Facility Related				\$35,022.00		\$ 5,131,020	\$ 4,854,365			\$ 408,612	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,131,020	\$ 4,854,365			\$ 408,612	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **PITTSFIELD HEALTHCARE CENTER**# **0043646** Report Period Beginning: **01/01/00** Ending: **12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	(2,182)	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	48,545	2
3. Under or (over) accrual (line 2 minus line 1).	\$	50,727	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	(2,162)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$0 For 19 2000 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	48,565	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	24,109	8		FOR OFF USE ONLY	
	1996	25,971	9			
	1997	45,446	10	13	FROM R. E. TAX STATEMENT FOR 1999	13
	1998	46,969	11	14	PLUS APPEAL COST FROM LINE 5	14
	1999	48,545	12	15	LESS REFUND FROM LINE 6	15
				16	AMOUNT TO USE FOR RATE CALCULATION	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
30,894

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories
1

C.
Does the Operating Entity?

☒
(a) Own the Facility

☐
(b) Rent from a Related Organization.

☐
(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.
Does the Operating Entity?

☒
(a) Own the Equipment

☐
(b) Rent equipment from a Related Organization.

☐
(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐
YES
☒
NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	242,194	1998	\$ 137,500	1
2					2
3	TOTALS	242,194		\$ 137,500	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1998	1970	\$ 2,020,231	\$ 67,341	30	\$ 67,341	\$	\$ 196,411	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpet		1998		764	153	5	153		331	9
10	Replace Sink		1998		5,913	296	20	296		616	10
11							7				11
12	Signage		1998		464	46	10	46		120	12
13	Seal, Coat, Patch - Parking Lot		1998		6,338	792	8	792		1,717	13
14	Replacement Doors		1999		6,619	441	15	441		883	14
15	Steel Door		1999		566	38	15	38		75	15
16	Carpet Install		1999		2,000	400	5	400		800	16
17	Generator		1999		1,031	52	20	52		95	17
18	Met/Glass Door		1999		1,779	89	20	89		163	18
19	Repairs to Nurse Call System		1999		817	82	10	82		143	19
20											20
21	Install A/C		1998		1,746	175	10	175		407	21
22	Install A/C Unit		1998		5,200	520	10	520		1,127	22
23	Boiler Repair		1999		1,100	55	20	55		64	23
24	Shower Tile		1999		680	34	20	34		40	24
25	Compressors (2)		1999		1,732	115	15	115		125	25
26											26
27	A/C Unit/Airhandler		2000		6,980	155	15	155		155	27
28	Floor and Piping Repairs		2000		2,089	52	10	52		52	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 2,066,049	\$ 70,836		\$ 70,836	\$	\$ 203,324	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 215,486	\$ 30,744	\$ 30,744	\$	Var.	\$ 84,252	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 215,486	\$ 30,744	\$ 30,744	\$		\$ 84,252	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 2,419,035	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 101,580	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 101,580	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 287,576	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				<u>Not Applicable</u>			4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: Not Applicable *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,608 Description: Dishwasher (\$147), Scaffolding (\$65), Copier (\$1,396)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			<u>Not Applicable</u>		19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$

13. /2002 \$

14. /2003 \$

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39.3	# of prescripts			240	15,845			16,085	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify): Ancillary Services	39.2, 39.3					27,386			27,386	13
14	TOTAL			\$		\$ 240	\$ 43,231		\$	43,471	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 23,084	\$	1
2	Cash-Patient Deposits	9,158		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 63,215)	268,342		3
4	Supply Inventory (priced at Cost)	15,121		4
5	Short-Term Investments			5
6	Prepaid Insurance	6,021		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 321,726	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	137,500		13
14	Buildings, at Historical Cost	2,062,334		14
15	Leasehold Improvements, at Historical Cost	6,802		15
16	Equipment, at Historical Cost	212,399		16
17	Accumulated Depreciation (book methods)	(287,576)		17
18	Deferred Charges	2,190,404		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,321,863	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,643,589	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 225,836	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,158		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(2,182)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany SLP Texas	535,822		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 768,634	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,854,365		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,854,365	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,622,999	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (979,410)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,643,589	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (369,055)	1
2	Restatements (describe):		2
3	Audit Adjustments	459,745	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 90,690	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,070,100)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,070,100)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (979,410)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,604,063	1
2	Discounts and Allowances for all Levels	(1,473,601)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,130,462	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,526	6
7	Oxygen	37,837	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 168,363	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	400	13
14	Non-Patient Meals	653	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	217,236	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,489	19
20	Radiology and X-Ray	1,966	20
21	Other Medical Services	9,312	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 245,056	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	267	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 267	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,544,148	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	433,198	31
32	Health Care	892,556	32
33	General Administration	285,737	33
	B. Capital Expense		
34	Ownership	904,934	34
	C. Ancillary Expense		
35	Special Cost Centers	43,471	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,614,248	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,070,100)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,070,100)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Extended If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **PITTSFIELD HEALTHCARE CENTER**# **0043646**Report Period Beginning: **01/01/00**

Ending:

12/31/00**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,847	5,655	61,004	10.79	3
4	Licensed Practical Nurses	13,498	15,748	167,225	10.62	4
5	Nurse Aides & Orderlies	43,727	51,015	386,674	7.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,918	2,238	16,868	7.54	9
10	Activity Assistants	2,099	2,449	12,134	4.95	10
11	Social Service Workers	1,944	2,268	18,190	8.02	11
12	Dietician					12
13	Food Service Supervisor	1,946	2,270	17,463	7.69	13
14	Head Cook	6,864	8,008	51,401	6.42	14
15	Cook Helpers/Assistants	6,777	7,907	43,256	5.47	15
16	Dishwashers					16
17	Maintenance Workers	1,939	2,262	18,811	8.32	17
18	Housekeepers	9,211	10,746	55,187	5.14	18
19	Laundry	4,893	5,709	30,405	5.33	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,049	4,724	30,511	6.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Nursing Admin.	1,997	2,330	40,554	17.41	33
34	TOTAL (lines 1 - 33)	105,709	123,329	\$ 949,683 *	\$ 7.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 4,041	1.3	35
36	Medical Director	Monthly	5,650	9.3	36
37	Medical Records Consultant	Monthly	654	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	53,720	10(a).3	40
41	Occupational Therapy Consultant	Monthly	35,774	10(a).3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	3,924	10(a).3	43
44	Activity Consultant	Monthly	2,501	11.3	44
45	Social Service Consultant	Monthly	2,501	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 108,765		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number

PITTSFIELD HEALTHCARE CENTER

STATE OF ILLINOIS

0043646

Report Period Beginning:

01/01/00

Page 21

Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$

B. Administrative - Other

Description	Amount
Contract Business Office Manager	\$ 21,551
Contract Administrator	67,391
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 88,942

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	\$ 625
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 625

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 8,465
Unemployment Compensation Insurance	14,054
FICA Taxes	65,406
Employee Health Insurance	18,540
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	\$ 106,465

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	667
Health Care Worker Background Check (Indicate # of checks performed)	96
Advertising/Public Relations	4,590
Professional Dues/Licenses	1,027
Less: Public Relations Expense	(4,590)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,790

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	8,273
Seminar Expense	300
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 8,573

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number **PITTSFIELD HEALTHCARE CENTER**

STATE OF ILLINOIS

0043646

Report Period Beginning:

01/01/00

Ending:

Page 23

12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. NO
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,262 Line 10.3
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,352
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 218
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? Immateri
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NO - MINOR
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.